SWAPNA VAIDYA, M.D.

PSYCHIATRY

Swapna Vaidya MD FAPA FACLP LLC (Online TelePsychiatry Practice Only)- Contact via website .

GENERAL INFORMATION

Name: _____ DOB: _ Sex: _

Mailing Address: _____

City, State, Zip: _____

SSN: _____ Employer: _____

Home Phone: _____ May we leave a message? Yes ☐ No ☐

Work Phone: _____ May we leave a message? Yes ☐ No ☐

Cellular Phone: _____ May we leave a message? Yes ☐ No ☐

MEDICAL AND REFERRAL INFORMATION

Name of Primary Care Provider: _____

Telephone Number: _____

Who referred you to this practice? _____

EMERGENCY CONTACT

Who should we contact in case of an emergency?

Relationship to you:
Home Phone: Cellular Phone:
Other:

For an Initial appointment only - Please understand that having an Initial appointment scheduled does not guarantee that a treatment relationship has been established between Dr. Vaidya and myself. Similarly, keeping that scheduled appointment does not mean that Dr.Vaidya has agreed to be my doctor or that I have agreed to be her patient.

An initial appointment is a consultation and it is an opportunity for both Dr. Vaidya and myself to evaluate if a treatment relationship should be started. Only when Dr. Vaidya and I both agree to it, will we formally be in a treatment agreement.

Initial here _____

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PRIMARY HEALTH INSURANCE

In order for any claims to be submitted to your health insurance company the following information must be completely filled out and submitted with a clear copy of the front and back sides of your insurance identification card(s).

THIS IS NOT NEEDED AT THE MOMENT

PRIMARY HEALTH INSURANCE

Primary Insurance Company: _____

Insurance Company Telephone: _____

Insurance Company Address: _____

City, State, ZIP: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _

Patient ID: _ Patient Birth Date: _____

*Subscriber on Policy: _____

Subscriber ID: _____ Subscriber Birth Date: ____

Subscriber Insurance Group #: _____ Subscriber SSN: _____

Subscriber Address: _____

**THE SUBSCRIBER IS THE INDIVIDUAL IN WHOSE NAME A CONTRACT IS ISSUED OR THE EMPLOYEE COVERED UNDER AN EMPLOYER'S GROUP HEALTH CONTRACT.*

SECONDARY HEALTH INSURANCE

Secondary Insurance Company: _____

Insurance Company Telephone: _____

Insurance Company Address: _____

City, State, ZIP: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _

Patient ID: _ Patient Birth Date: _____

*Subscriber on Policy: _____

Subscriber ID: _____ Subscriber Birth Date: ____

Subscriber Insurance Group #: _____ Subscriber SSN: _____

Subscriber Address: _____

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AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION FOR TREATMENT, BILLING, OR HEALTHCARE OPERATIONS

I understand that I have the right to review the Privacy Notification prior to signing this consent. I understand that Swapna Vaidya M.D. reserves the right to change their notices and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations. I understand that I may revoke this consent in writing, except to the extent that Dr. Vaidya and support staff have already taken action in reliance thereon. I also understand that Dr. Vaidya and her support staff are not required to adhere to the restrictions requested in the event of a potentially life-threatening emergency.

Records may be needed in order to process a claim for medical services. I authorize Swapna Vaidya , M.D. to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories. I understand that by signing below, I am authorizing the release of all or part of my medical record for the purpose of my treatment, billing, or pertinent healthcare operations. This release may include records containing information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under contract for all or part of the medical charges, including but not limited to, Medicare, Medicaid, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer.*

**The patient's employer will only be contacted if necessary in order to confirm enrollment in a healthcare plan.*

Patient Signature: _____ **Date:** _____

Patient Printed Name:

ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for all charges as this practice does not accept insurances at the moment

Patient Signature: Date:

Patient Printed Name: